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Renewed Health ~ 5010 NE 33rd Ave ~ Portland, OR 97211

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Patient's Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Name's: _____

Telephone (home): _____ (Parent's work): _____

Patient's Age: _____ Date of Birth: _____ Gender: Female / Male

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

Name of Pediatrician _____

Phone _____

Reason for Visit Today: _____

MEDICATIONS

NOW PAST

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_____ Aspirin _____ Decongestants

_____ Tylenol _____ Anti-histamine

_____ Antibiotics _____ Other _____

_____ Ibuprofen Allergies to medicines: _____

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, approx no. of times: _____

_____ Measles _____ Pneumonia _____ Ear infections, approx no. of times: _____

_____ Mumps _____ Frequent colds _____ Strep throat, approx no. of times: _____

_____ Rubella _____ Rheumatic fever _____ Other: _____

Has your child ever had any of the following? WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS

_____ MMR _____ DPT _____ Chicken pox _____ Others: _____

_____ Measles _____ Diphtheria _____ Small pox Adverse reactions: Y / N

_____ Mumps _____ Tetanus _____ H. influenza If so, what? _____

_____ Rubella _____ Polio _____ The flu _____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects _____ Mental illness _____ Cancer

_____ Hypertension _____ Arthritis _____ Tuberculosis _____ Osteoporosis _____ Asthma

____ Allergies Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

____ Bleeding ____ Nausea ____ Physical or emotional trauma
____ Illnesses ____ Hypertension ____ Cigarettes, alcohol, drug consumption
____ Medications ____ Diabetes ____ Thyroid problems Other _____

BIRTH HISTORY

Term: ____ Full ____ Premature ____ Late Weight at birth: _____

Length of labor: _____ Complications: _____

Did your child have any of the following problems shortly after birth?

____ Rashes ____ Birth injuries ____ Blue baby
____ Jaundice ____ Seizures ____ Cerebral palsy
____ Colic ____ Fever ____ Birth defects
____ Other: _____

Child's sleep patterns (1st year): _____

Food intolerances: _____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk, soy): _____

Age began solids: _____ Which foods: _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

____ Hives	____ Burning urine	____ Bloody uring	____ Eczema
____ Cries easily	____ Bleeding gums	____ Heart murmur	____ Nervous
____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Asthma
____ Acne	____ Anemia	____ Night sweats	____ High fevers
____ Jaundice	____ Sensitive to light	____ Chronic rash	____ Stomach aches
____ Diarrhea	____ Hearing loss	____ Easy bruising	____ Sore throats
____ Flat feet	____ No appetite	____ Body/breath odor	____ Constipation
____ Nightmares	____ Frequent colds	____ Bleeding tendency	____ Unusual fears
____ Wheezing	____ Joint pains	____ Excessive fatigue	____ Cough
____ Dizzy spells	____ Hair loss	____ Frequent urination	____ Allergies

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

THANK YOU. I LOOK FORWARD TO HELPING YOUR CHILD IN ANY WAY I CAN.